HEALTH EDUCATION

COMPREHENSIVE GUIDELINES

ON

PLANNING, IMPLEMENTATION AND EVALUATION

OF

World Health Organization
Regional Office for South-East Asia
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CORRIGENDA

Please make the following corrections in the publication "Health Education—Comprehensive Guidelines on Planning, Implementation and Evaluation of Health Education (April 1969):

Page	*Correction*
Table of Contents	Correct page number against the last item to *read* as 16.
1	In para 5, line 2, *delete* "or" before "in" and the comma after "essential".
8	In the footnote *delete* the colon and the words "*Community Health Services*".
13	In the first paragraph under *STEP VI. DEVELOPMENT OF A DETAILED PLAN FOR EVALUATION OF HEALTH EDUCATION*, third line, *delete* "(a)" after "item 14".
14	In the last line, *read* "items" *for* "item".
17	In the first line against item 15. Demographic characteristics, *add* a comma after the word "fertility".
18	In the footnote, *read* "p. 110" *for* "110 p.".

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1. INTRODUCTION

The material contained in this document was evolved at an inter-country workshop held in the South-East Asia Regional Office of the World Health Organization, New Delhi, from 6 to 17 November 1967. Participants in the Workshop were public health administrators, health education specialists and personnel concerned with training from Member countries of the Region.

The Workshop was one of a series of activities in an inter-country project on the methodology of planning, implementation and evaluation of health education. Under this project, country working groups had been organized in the countries of the Region to study the health education situation and, particularly, to carry out a study to pre-test draft guidelines for planning health education in programmes on the following subjects: smallpox eradication, leprosy control, tuberculosis control, malaria eradication and nutrition. The results of these trials were made available to the participants for redrafting the guidelines for planning. Guidelines for implementation and evaluation were drafted before the Workshop took place and, together with those for planning, were further tested by applying them to three other health programmes: (a) maternal and child health—protein malnutrition in children in the 1-3 year age-group, (b) tuberculosis, and (c) environmental hygiene—safe water supply.

On the basis of the above experience the present comprehensive Guidelines were prepared and were issued as Part B of document SEA/HE/28, Report of an Inter-country Workshop on Planning, Implementation and Evaluation of Health Education. During 1967 and 1968 the Guidelines were further tested in actual use in programme planning in several countries and, in 1968, were used in a workshop on health education in Indonesia. As a result of this experience, certain modifications have been incorporated in the present version. Explanatory notes are included immediately under each item, and a glossary is attached.

Public health programmes and services which depend, for implementation, upon action by the people have a health education component. Health education is the method of choice to help people learn what to do themselves and how to do it to have better health.

The Guidelines should serve as a step-by-step, scientific procedure for planning the health education component of all programmes or in which it is essential, for the success of the programme that the people should play their part well. They follow the main steps in scientific planning, which are: identification of the problem, setting objectives, assessment of resources, consideration of possible solutions, preparing a plan of action, implementing the plan and evaluating the outcomes.

Although set out in the form of questions, the Guidelines are not meant to be used merely to get replies to these questions. When they are applied to a particular health programme, each question will constitute a step in the scientific plan. The replies to the questions should therefore provide information for a comprehensive health education plan, including implementation and evaluation of the health education component of the health programme in question.

A number of references to the collection of data necessary for planning are found throughout. To facilitate the collection of such data required for planning, the planners may wish to review the entire set of questions in order to ascertain exactly what data will be required and arrange to have them collected and put into a form suitable for utilization at the particular time they are needed, in following the different steps of the planning process. They may wish to arrange for all data to be collected at one time in order not to return to the same source again and again for information. Attention is called to the explanatory note to item 17 of the Guidelines, which lists many items which it may be desirable to consider when planning for the collection of data.

The Guidelines are designed for use by the planning team, i.e., jointly by the health administrator or programme director, the health education specialist and any other persons who should logically join the team for

planning health education. The team might also include the members of the country working groups which were set up in the first stage of the project.

It is suggested that the Guidelines may also be used in training programmes, particularly in schools of public health and institutes of hygiene, as a basis for teaching planning and evaluation and for the planning of health education in field areas, in order to demonstrate their use and to teach students to use the Guidelines in their concurrent practical work and field training.

Reports on the experience in the use of the Guidelines and suggestions for improving them should be sent to the WHO Regional Office for South-East Asia, Indraprastha Estate, New Delhi 1, for use in further modification of the Guidelines.

2. THE GUIDELINES

STEP I. IDENTIFICATION OF THE HEALTH PROBLEM AND CONSIDERATION OF GOALS IN PLANNING A HEALTH EDUCATION PROGRAMME

Health education cannot be planned in general terms or in a vacuum. It is planned in connection with a specific health programme or health service. Therefore, it is essential for the planners to know the health programme or service well, and Step I therefore relates to the health problem for which health education is to be planned. While selection of the health problem is an administrative decision, the health education service should provide information relevant to the selection, particularly as indicated in items 1(c)(2) and 1(c) (3) below.

1. The Health Programme

(a) What is the health programme in which health education is to be planned?

(b) What health problem is the programme expected to help in solving?

The specific problem should be clearly stated. Information about the problem called for in 2(a) may be useful in stating the problem clearly.

(c) What were the considerations in selecting the problem which the programme is intended to solve?

These should be stated in clear, specific terms; for example, in smallpox, whether the criterion used was mortality and morbidity, or the availability of a potent vaccine; also information about the people's understanding and how they view the disease.

(1) How is the health problem seen by health experts/administrators?

The priority which the administrators give to the problem in relation to other health problems should be known to the planning team. For example, smallpox may have a high priority as a public health problem in some countries and a very low priority in others where there are no smallpox cases.

(2) How is the health problem seen by the people, and what importance do they give it?

Information as to whether they recognize the problem and, if so, the importance given to it in relation to their other problems will enable the team to know how much effort may be required to get the people to recognize the problem, as well as to take necessary action.

(3) What is the predicted feasibility of solving the problem?

To assist the administrator in selecting the problem, the team should collect information on whether its solution is within the economic reach of the community, whether the people are willing to take the necessary action and what factors, if any, would make it sselection unwise.

2. Nature and Scope of the Problem

(a) What are the epidemiological considerations viz.,

(1) Magnitude (size, seriousness, severity),
(2) Population group affected,
(3) Geographical distribution, and
(4) Seasonal distribution ?

Detailed epidemiological data specific to the area and to a period of time would help the health education service to know where to focus the activities. If such data are not available, the planning team should plan to collect them, if possible.

(b) What health or other means of solving the problem is available ?

"Health or other means" refers to definite ways of solving the problem which are known and are available to the particular community or country. The means in this context denotes a "weapon" or "a combination of weapons" by the use of which a solution to the problem will be achieved. The means could be a potent vaccine for prevention, like BCG for tuberculosis; effective curative drugs like the sulphones for leprosy or a food supplement for use against protein malnutrition.

(c) What are the implications for health education in (a) and (b) above ?

There are implications for heal. . education whenever there is an opportunity to help people perform any action to improve their health. This means an opportunity to carry out health education work in the programme selected. The scope of the implications will vary from one situation to another. For example, if the answer to (a) shows that the problem is found mainly among infants in three districts, and an effective means—the answer to (b)—is easily available to solve the problem, health education work might be included in the routine maternal and child health activities in these districts in order to reach the families of the infants. However, if the problem is polluted water used by all the people in a large city, health education in this regard might have to reach (i) the official leaders, (ii) the agencies or groups which influence the masses, and (iii) the masses themselves. The means might include many measures (some of which might be costly) and would require the participation of nearly all the population; the planning for health education would be long term, and hundreds of people would be involved in the implementation. The methods of collecting information for (a), (b) and (c) offer opportunities for health education, since the health educator, the administrator or any other person engaged in the collection of data can demonstrate an educational attitude towards others and can influence those who give the information.

3. Phases of the Programme

(a) What are the phases, the timing of each phase and other essential data?

Certain programmes are carried out in phases. In smallpox eradication, for example, there are the attack, consolidation and maintenance phases. In others, such as an applied nutrition programme, only a part of the programme is implemented at one time. The initial stage might include the feeding of vulnerable population groups, e.g., mothers and children, rather than other groups of the population.

The duration of each phase or part of the programme and of the entire programme must be specified to enable the planning of the health education programme.

(b) What are the specific programme goals—ultimate, intermediate and immediate—which are to be achieved in solving the problem?

The information required here is different from that on the educational objectives called for in item 14(a). The programme goal is the outcome expected from the organized health programme or health services directed toward a specific health problem.

The planning team should clearly indicate the stage of the health programme or the period of time in which each programme goal (immediate, intermediate and ultimate) is to be achieved. For example, in smallpox, the *immediate* goal could be to reduce the incidence of cases to 1 per 1000 in two years; the *intermediate* goal might be to control the disease in three years (which would mean no secondary cases after three years of operation), and the *ultimate* goal would be eradication in four years (which would mean no cases at all at the end of the four-year period).

(c) What are the social implications and social costs, taking into account the people's habits, customs, values, and way of life?

(d) What likelihood is there of achieving the programme goals, considering the people's response, service facilities, personnel and other resources?

Information about the people collected by the planning team should be made available to help the administrator to state the programme goal more specifically.

STEP II. DETERMINATION OF DESIRED PRACTICES AND ANALYSIS OF FACTORS INFLUENCING CHANGE

Before making an educational diagnosis of the changes that need to be made in the practices of a particular group, it is necessary for the programme head or expert to indicate the ideal behaviour or practices on the part of the people to achieve the programme goal. The questions in Step II are designed to help the planners to get information on ideal practices and the extent to which these already exist, and also to assess the factors that are supportive or those which act as barriers to ideal practices. Although answering these questions is a team responsibility, the health educator may be expected to contribute more information than the other members of the team.

4. Programme Measures

What are the programme measures to be taken to achieve the programme goals stated in item 3(b) above?

The term "programme measures" refers to the activity or group of activities carried out to see that the health or other means stated in item 2(b) above are applied or are provided as services to the people needing them (e.g., giving vaccinations, spraying DDT, prescribing drugs in ambulatory treatment).

5. Acceptability and the People

(a) To what extent are these measures likely to be acceptable to the people? Are they in tune with their way of life? Are they feasible?

Health measures which are in tune with the people's way of life are, in general, those that are most readily accepted by the people. It follows that health measures must be planned in such a way as to be in harmony with existing habits.

(b) Which health practices should the people accept and adopt so that the programme goals stated under 3(b) above can be achieved?

The team should categorically and clearly state what the people should actually do in relation to each programme goal. What they are expected to do may depend on many factors, including the type and extent of the health services available, whether the community is urban or rural, etc. For example, in smallpox eradication, when vaccination is provided by house-to-house visits, the action required of the people is only acceptance; however, when vaccination is given only in clinics or health centres, a different action is required of the people: they must go to the clinic and request vaccination, or accept it if it is given when they visit the clinic for other purposes.

6. Target Groups

(a) Which population groups should accept each of the health practices indicated in item 5 (b)?

The population group to accept each practice should be stated clearly. In solving the health problem, the aim may be for the desired health practices to be carried out by (i) the entire population or (ii) by special groups only. For example, in a tuberculosis programme the population group which should accept the health practice of taking drugs daily as treatment is limited to the patients confirmed to be suffering from the disease. On the other hand, in dealing with smallpox, the entire population should accept the health practice of getting vaccinated; however, the priority target group(s) for primary vaccination may be only infants under six months.

(b) Which are the target groups for health education?

Health education is aimed at helping people to take action to improve their own health. These are those individuals or groups in the population who are in the best position to take the action required, or to influence its being taken. For example, women would be in the best position to boil rice so as to conserve food nutrients. Religious leaders might exercise great influence in making the people accept DDT spraying. Mothers of infants under six months of age might be the group to determine whether to get these infants vaccinated or not. Therefore, the above groups would be the target groups for health education on the specific health practice, since they influence the action or take the action themselves.

7. Present Practices of the People

(a) Which practices listed in item 5(b) are now being followed by the people, and to what extent is each practice carried out by different population groups in the community ?

To enable the team to make a realistic plan for health education, it will be necessary to know in detail what the people are already doing as compared to what they need to do to achieve the stated programme goals, and what more needs to be done. For example, when the baby is being fed only on liquids, the mother needs to know about adding solid food containing essential nutrients to the baby's diet.

In some cases, only a part of the population needs to take action; for example, if 100% vaccination is the aim and 65% have already accepted it, the action needed is by the 35% not yet vaccinated.

(b) What are the reasons for the people's following or not following each practice listed in item 5 (b)?

(c) What current practices need to be done in a different way?

The people may need to do things in a different way in order to comply with actions called for in item 5(b). For example, they may need to cook rice in a smaller quantity of water and keep the vessel covered while cooking in order to preserve the nutrients. In some cases they may need to take up a new action, such as reporting smallpox cases or going to the health centre for confinements.

(d) What practices should be given up or stopped, and why?

Also, they may need to stop doing some things they have been doing, such as spitting in public places or drinking water from contaminated sources (tanks, rivers or even wells) without boiling it.

8. Social, Psychological, Cultural, Economic, Physical and Other Factors

(a) What are the factors which help support and promote acceptance and adoption of the health practices mentioned in item 5(b)?

Example: A readily available water supply should help people adopt the practice of taking a bath daily.

(b) What are the factors which hinder or limit acceptance and adoption?

Example: The existing practice of feeding the baby with only liquids until one year of age limits or prevents the adoption of the recommended practice of giving solid food to babies at an early age of three months or so.

9. Attitudes of the People

(a) What are the positive attitudes towards health and welfare services, personnel and agencies, and what are the experiences that led to such attitudes?

Example: Trust in the vaccination team.
Prompt attention by the vaccination team to cases of severe reaction brought about the trustful attitude of the family and community.

(b) What are the negative attitudes, and the experiences that led to them?

Example: Refusal to attend clinic for vaccination.
The headman's family travelled a long distance to the vaccination clinic, but no vaccine was available there.

10. Changes Necessary in the Health Services Provided

To bring about the desired behaviour, must any aspects of health services provided directly at the homes or in the community be supplemented or modified? If so, which aspects, and in what way?

The data so far collected may give sufficient indication of alterations which need to be made in the services offered. If, for example, a vaccination clinic had to be cancelled for want of vaccine, it is clear that announcements about holding such clinics should not be made until it has been ascertained that the necessary vaccine is available. Or, the hours for DDT spraying may need to be changed to hours during which the farmers are at home.

STEP III. ASSESSMENT OF APPARENT AND POTENTIAL RESOURCES

Regardless of the need for or objectives of a programme, what can actually be done will depend to some extent—and often to a large extent—upon the resources available, e.g., resources in the form of men, money and materials. Step III is intended to reveal the resources available to the programme under consideration, and to assess their potential and specific assistance in the health education programme.

11. Workers To Be Involved

(a) What are the different categories of health and welfare workers who could be involved in this programme? What are their regular duties and their training and background in health education? What supervision in health education have they been given?

(1) Workers (or category of workers)
(2) The main duties of each category
(3) Health education duties specified for each category
(4) Training received by each category in health education
(5) Supervision received by each category in health education, and from whom it is received.

Since the numbers and categories of available health and welfare workers and the kinds of duties they perform have a bearing on the determination of health education activities, a list of the workers or, at least, of categories of workers (as under (1) above), and all details called for under (2), (3), (4) and (5) will be needed. The term "welfare workers' means those who are in or outside govern-

ment service and are working for welfare programmes, e.g., health workers, teachers, community development workers, etc. The following format is suggested to facilitate proper recording:

Category of workers who could be involved in their programme	Their main duties	Duties in health education already specified	Training in health education received	Category of staff who supervise the health education duties listed in Column (3)
1	2	3	4	5
A. Health workers				
B. Other welfare workers				
C. Others, if any				

(b) What are the main difficulties to be overcome in involving health and welfare workers in the carrying out of health education in this programe?

These might include such difficulties as the lack of prior training in health education, the shortage of supervisory staff, budget cuts, or the sharing of administrative authority with another agency.

12. Resources

What resources, in addition to the personnel listed in the answer to item 11(a), are available to assist this programme in health education? What would the type and extent of potential contribution be, e.g., service, personnel training facilities, funds and the like (list separately for each)?

(a) Governmental agencies (such as health, community development, information, education, agricultural and labour departments and local bodies) and inter-governmental agencies.

(b) Voluntary agencies (such as the Red Cross) and other international non-governmental organizations, professional organizations, workers' organizations, religious and philanthropic organizations, women's and youth organizations.

(c) Medical and paramedical training institutions.

These may include all kinds of government and private institutions which undertake the preparation of health workers of all types.

(d) Official and non-official leaders.

Here, all persons whose words and action have an influence on the behaviour of the people should be listed. They would include formal leaders like village headmen, paid workers such as teachers, informal leaders like village priests, etc.

(e) Other community resources (such as local commercial agencies, libraries, and cultural centres).

STEP IV. ESTABLISHING THE EDUCATIONAL OBJECTIVES

Data collected from answers to questions in Step IV are indispensable for the planning, implementation and evaluation of the health education component of the programme. Information given in item 1.4(a) is really the key to health education in the programme and is its basis. A clear statement of objectives is essential for planning the programme (Step V) and for evaluating it (Step VI).

13. Planning Health Education in an On-going Programme

(a) To what extent has health education been previously included in this programme?
(b) What are the health education objectives?
(c) What health education activities have been carried out, and what were the results?

Unfortunately, the health education component of a health programme may often not have been considered in the initial stages and may be taken up long after the programme has been launched. When this is the case, the specific details of whatever health education has already been provided and carried out should be stated here.

14. Health Education Objectives

(a) On the basis of information thus far gathered, what are the definite health education objectives (immediate, intermediate, and ultimate) of this programme?

As "health education objectives" one should state exactly what behaviour is to be changed in order to ensure the action outlined under item 5(b), exactly what the people are to do, or what change is to be achieved by a certain time. The statement may be in terms of immediate, intermediate or ultimate objectives, as illustrated in the chart given under item 29. An educational objective is always stated in terms of the action to be carried out by the people concerned or in terms of a change in their behaviour.

The health education objectives in relation to the "health programme goal" may be illustrated as follows. The programme goal may be "To give primary vaccination to all newborns," whereas the health education objective would be "To bring about the necessary action on the part of the people so that they will accept vaccination and the programme goal may be achieved." It is emphasized that to bring about this action, there may have to be many sub-objectives, such as providing knowledge on smallpox as a serious disease, or to the effect that vaccination protects a person, or that vaccination is available at centres in specified places.

(b) Is each objective specific enough for evaluation purposes?

If the accomplishments are to be measured, a clear statement of the educational objectives will be necessary. The following criteria are suggested[1];

(1) A clear definition of what is to be attained; for example, "primary vaccination" of all children before they are six months of age.
(2) A clear statement of the amount or degree of intended attainment; for example, 100% of the children must have primary vaccination before each child is six months old.
(3) A clear statement of the time in which this degree of attainment is expected; for example, "between 1 July and 1 September 1968".
(4) A clear specification of the geographic location of the programme; for example, Bata village.
(5) A clear specification of the particular people, or the portion of the environment, in which the objective is to be attained; for example, the parents of all children under six months of age should have these children vaccinated.

The objective might read, "To persuade parents of children under six months of age in Bata village to have all these children (100%) vaccinated between 1 July and 1 September 1968".
Sub-objectives might include the following:

(1) "To carry out a house-to-house survey of the village in order to list the names of all the infants under six months."
(2) "To identify leaders, especially among the women who can assist with this survey."

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[1] Adopted from *Procedure for Evaluating Health Programmes: Community Health Services*, School of Public Health, University of Ann Arbor, Michigan, U.S.A.

The programme's success depends on accomplishment of the sub-objectives. Sometimes a sub-objective may not be directly related to health. If the objective were "To get 50% of the restaurants in a given locality to reach a specified level of cleanliness in one year," one sub-objective might be "To have restaurant owners buy new uniforms for the staff."

15. Responsibility for Developing the Plan of Operation

Who will have the responsibility for developing the detailed plan of operation for health education in this programme?

The entire planning team should be involved, but the health educator, where there is one, should be mainly responsible for preparing the plan of operation, with support and help from the planning team and other relevant staff. However, whether or not a qualified health educator is present, the planning team should specify the person to be responsible for planning the health education programme at each level of administration (national, zonal, provincial, state, or local).

16. Provision for Evaluation

(a) What are the provisions for evaluating the achievement of the educational objectives?

If evaluation is to be carried out, it is necessary to plan for it at the same time that all the other planning is done.

(b) Who will be responsible for evaluation?

The person responsible for evaluation should be specified or agreed upon at the planning stage.

(c) How much staff time and funds are available for evaluation?

The funds available and the amount of time the personnel can give to this work will, of course, influence the evaluation plan.

(d) When will evaluation be done?

(e) What arrangements are necessary at this stage of planning for changing programme operations later in the light of evaluation findings?

One of the purposes of evaluation is to have a continuous "feed-back" or flow of information from findings, which will form the basis for making suitable modifications in the health services or health education activities or both. The planning team at this stage should ensure that there is in the plan, the necessary mechanism for making either major or minor modifications as may be necessary.

STEP V. DEVELOPMENT OF A DETAILED PLAN OF OPERATION FOR HEALTH EDUCATION

Before a detailed plan of action is laid out, a starting point must be set by collecting baseline data concerning the area and the people. Attention is called especially to the explanatory note under *item 17*, which refers to other guidelines to be considered in collecting baseline data. The action programme is then planned in detail to carry out the health education component of the programme, i.e., to help the people help themselves to have better health.

17. Baseline Data

(a) What baseline data about the area and the people to be covered by the health education programme will be essential for planning, implementing, and evaluating that programme?

Since all information called for in item 17 may not be readily available, the planning team may arrange for surveys, study records and reports, interview workers, or use other means of collecting the necessary data.

In order to plan for the systematic collection of data it is suggested that the following items also be considered along with item 17: .

1 (c) (2) and (3)
2 (a)
3 (c) and (d)
5 (a)
6 (b)
7 (a) and (b)
8 (a) and (b)
9 (a) and (b)
11 (a) and (b)
12 (a) to (e)
13 (a) to (c)
16 (b) to (d)
18 (a) to (c)
19
21 (a) and (b)
23 (a) and (b)
24
25
31
32 (a) to (d)
33 (a) to (c)
34
35

(b) Describe the demographic characteristics and literacy.

See glossary.

(c) What is the socio-economic status of the people?

Here, information on the average income, the type or quality of housing and the level of education should be included.

(d) What are their social and cultural characteristics?

Information on the people's beliefs, taboos, customs, superstitions; cultural events like festivals and fairs; patterns of events like marriage; and food practices should be included here.

(e) Describe the participation patterns and social organizations.

Examples: "Men gather at the tobacco or tea shop every evening"; "Two women are members of the panchayat"; "Only women make decisions about DDT spraying in village X"; "There are ten social groups in village Y." The type of organization and a description of it should be given; for example, "Two women's associations with 50 members from seven communities."

(f) What are the patterns of leadership?

All persons whose words and actions have an influence on the behaviour of the people should be listed as leaders. There could be formal leaders like the village headman or sarpanch; paid workers like teachers or sanitary inspectors; informal leaders such as religious priests, etc. The information should be specific. For example, "The most influential leaders are the headman and Mr Z, who runs the rice-mill; the leader for health work in the family is the mother of the head of the family, i.e., the housewife's mother-in-law."

(g) What is the level of the people's co-operation as evidenced by the previous programme?

Example: "In the beginning, 95% of the people responded favourably to indoor insecticide spraying, but last month 50% of them refused." Refer also to answers to 9.

(h) What are the topographical and ecological characteristics of the area?

See glossary. Example of topographical characteristics: "Villages are small and widely scattered." Examples of ecological factors: "Sandy soil and high winds irritate the eyes of the people in area K and make control of trachoma difficult," or "Water is very scarce between November and June, being sufficient only for drinking purposes."

(i) Describe transportation and population mobility.

Are the people permanent settlers, or are they on the move from place to place like nomads or certain types of labourers? A reference could also be made to the availability of transport for people to go to health centres or other health facilities.

(j) At what places and for what events do people congregate?

Examples: fairs, festivals, temples, churches, clubs, tea or coffee stalls, cultural centres, markets, cigarette and tobacco shops.

(k) What are the information media?

(1) Sources of information.
Examples: newspapers, health workers in the city, radio, etc.

(2) Channels of communication.
See glossary.

(3) Indigenous media.
See glossary.

(l) What physical facilities such as electricity are present?
List such facilities.

(m) What are the facilities and resources provided by agencies listed in item 12 above?

Examples: Funds for orientation camps for leaders from the health department; clinic space for an immunization centre in a building owned by a women's club; X high school with a Junior Red Cross group to help with an exhibition on home safety; art teacher at a boy's college willing to make directional signs for the clinic if the government furnishes the materials.

(n) Give other relevant data.

A review of the objectives may point to the need for other information, such as governmental plans for area development, the effect of forthcoming elections on personnel to be involved in the programme, and similar items.

18. Collection of Data

(a) How will the data be collected?

(b) Who will collect them?

(c) When will they be collected?

19. Involvement of the Community

Although the community may have been involved to some extent in the above fact-finding, what will its active involvement for health education purposes be?

For example, the community might be involved through community councils or committees, for planning, implementing and evaluating, for effective functioning and co-ordination. One way of securing continuous involvement of the community could be the use of existing committees or other organized groups (see item 12). Another way might be the forming of community councils or committees. When the constitution of such a body is being drafted, the nature of the council, composition of membership, functions, period of life foreseen, area of influence, etc., should all be spelt out in detail.

20. Target Groups

Which are the target groups for health education?

These groups should normally be the same as those given under item 6(b).

21. Opportunities for Health Education

(a) What health education opportunities are available:
  (1) In the community?
  (2) In institutions?
  (3) In the duties of each category of worker listed under items 11 and 12?

The team would assess the various opportunities and indicate those available to this programme. *Examples:* (1) *In the general community:* the manager of the radio station will accept a one-minute announcement on nutrition at any time; (2) *In institutions:* the professor of preventive and social medicine of a nearby medical college is interested in the possibility of his students' having more field experience in the trachoma programme; (3) *In duties of different workers:* The malaria surveillance worker visits every home once a fortnight and talks with at least one adult.

(b) Which of these opportunities would be useful in reaching the target groups identified in item 20?

22. Educational Activities

(a) What educational activities and efforts are to be undertaken to achieve the health education objectives?

After the planning team takes into consideration all the information listed under items 17 through 21 above, it carefully selects the specific activities and efforts which are educational and which, in its best judgment, should bring about the knowledge and attitudes leading to the desired practices listed in item 5(b).

(b) How are activities timed in relation to one another?

All should be planned and listed in logical sequence so that one activity supports or favourably influences the next in order.

(c) For each activity (in item 22(a)),
  (1) What is the factual or subject content?
  (2) What educational method will be suitable?
  (3) What educational media will be suitable?

Item 17 should also be considered in answering (2) and (3) in order to select suitable methods and media.

23. Persons or Organizations Responsible

For each activity (in 22(a)),
  (a) Which organizations or persons will be responsible?
  (b) What are the functions and detailed health education duties of each organization or person?

Refer to item 12 for resources available.

24. Supervision

Who will exercise continuous supervision over the various workers mentioned in answer to item 23(a) above, in carrying out the health education activities, including the proper use of health education methods and media?

The persons who will supervise the health education activities of each worker or category of worker should be specified.

25. Training

What training will be required for each category of personnel responsible for carrying out and supervising the health education activities mentioned in 22(a)?

The details of training requirements for each category of personnel should be worked out (based on answers to items 11(a) and (b) and 23 above). For each type of training (pre-service, in-service, orientation), details are needed on the content, methodology, period and place of training, and facilities required (including teaching aids, hostels, library, etc.). Similar details should be worked out for community leaders and volunteers in health education.

26. Co-ordination of the Programme

Who will act as the major co-ordinator of the health education programme to ensure that the plan is carried out and that the results of intermediate evaluations are utilized to modify the plan when indicated?

Refer to item 16 for arrangements for evaluation. Health education is the responsibility of a large group of health and welfare workers, of members of many agencies and organizations, and of the people and their leaders at various levels. To ensure co-ordination of the health education activities of all these workers, a person should be responsible at each level of administration (such as the national, district, provincial and divisional levels). The person responsible should be specified in the plan.

STEP VI. DEVELOPMENT OF A DETAILED PLAN FOR EVALUATION OF HEALTH EDUCATION

The idea of evaluation is generally accepted. The procedures for evaluation, however, are often not specified at the planning stage. Since evaluation is related to and dependent on objectives, the statement of objectives must be sufficiently specific to be measured (see item 14(a)). In fact, the more specific the objective, the better the possibility of making a useful evaluation. In addition, it is necessary in the planning stage to set the criteria to determine progress or success and to select the instruments to use in gathering the data. The persons responsible for the evaluation should have been indicated by the team, and this information recorded in reply to item 16(b).

27. Detailed Plan for Evaluation

(a) Does each of the health programme goals listed in answer to item 3(b) specifically indicate the time within which the goal is to be achieved, the geographical area and population group involved?

(b) Do the programme measures listed in answer to item 4 indicate the exact way in which the health problem can be prevented or controlled?

The health goal and means of solution should be reviewed and the appropriate information recorded in the plan at this stage.

28. Educational Objectives for Evaluation

(a) Does each educational objective mentioned in item 14(a) indicate precisely what will actually be measured?

(b) Does each indicate when the measurement will be carried out?

These should be reviewed and revised, if necessary, in the light of the criteria listed in answer to item 14(b), and the reply recorded, in the plan. Additional information would be given in the answers to item 16.

29. Flow Chart of Goals and Objectives

(a) Do the programme goals and educational objectives listed above in items 3(b) and 14(a) fit into a flow chart which shows the relationship between them?

(b) Does the flow chart indicate for each educational objective the educational activities which will be undertaken to achieve it?

Example: The set objective (ultimate goal) may be vaccination in two years of 100% of the children aged six months to six years of age; the objective for the first six months (immediate goal) 25%, and for the end of the first year (intermediate goal) 80%. For the intermediate goal of 80%, see chart on the next page.

30. Evaluation of Efforts and Activities

What are the educational efforts or activities which need to be evaluated for the improvement of the health education aspects of this programme ?

Indicate which of the items listed in answer to item 22(a) are to be measured.

31. Criteria of Progress

What will the criteria of progress or of ultimate success be for each objective in item 14(a)?

List in the plan the specific criteria for determining the extent to which each activity has been successful, referring to item 14(a). *Example*: If the immediate objective was for the nurse to make home visits to discuss the importance of primary vaccination with mothers of infants under six months of age in X, Y and Z villages in M Block between 1 November 1968 and 1 January 1969, the criterion of success might be "no less than 75% of the houses visited" (in villages that are large and scattered and served by only one nurse).

32. How to Measure Progress

(a) What methods and instruments need to be used to measure progress and ultimate success in view of the baselines?

The selected method to evaluate home visits referred to in item 31 might be for the clerk to count the visits listed in the nurse's monthly report (the instrument) at the end of each month, and to calculate the percentage visited on the basis of the recorded birth-registration (the second instrument). (See glossary.) Information under item 17 might indicate that some types of evaluation would be more suitable and feasible than others.

(b) At what levels?

(c) By whom?

(d) When?

For items 32(b), (c) and (d) check answers with items 16(a), (b), and (c).

33. Resources for Education

(a) What resources (equipment, funds, personnel, agencies, etc.) are needed to carry out the evaluation?

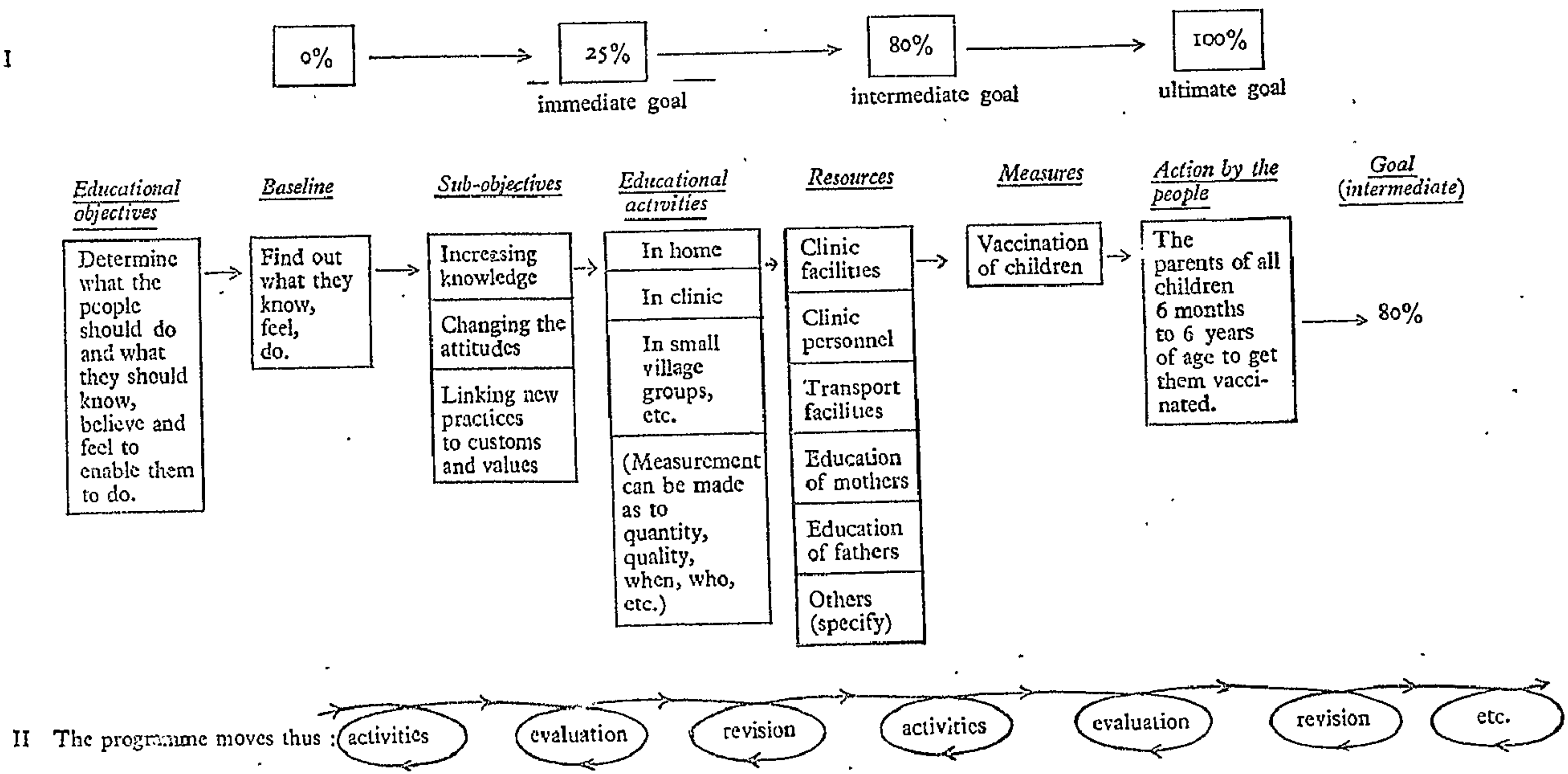
(b) What resources are lacking?

(c) Where and how can the resources given in answer to item 33(b) be obtained?

If it is possible to obtain them, the details of where and how they can be secured should be specified in the plan. If no available source is known, this should also be indicated. Check answers to item 33 with the information given under item 12 and 16.

Chart Illustrating Steps in the Plan for Evaluation of Health Education[1]

(Achievement of the intermediate goal)



[1] This is an adjusted version of the flow chart used by Professor Beryl Roberts in explaining the various steps or actions necessary to be taken to achieve a programme goal. To achieve the intermediate goal of 80% all the actions indicated on the above chart and possibly more would be required. Additional actions required would be indicated appropriately on the chart.

The diagram in II illustrates the use of evaluation as a continuous planning process, i.e. the use of evaluation findings to revise the programme to improve the operations.

34. Training Evaluators

What arrangements are there for the preparation and training of evaluators at various levels (different types of health workers, community leaders and others)?

The plans made for training evaluators should be given. See item 25 for items that might need to be considered in the training, and item 11 for training already received.

35. Using the Results

What is the plan for feeding evaluation results back to the planners and to those who are implementing the plan with a view to improving the programme, future programmes and the techniques of evaluation?

Refer to item 16(e) for arrangements to use the feedback. The team should specify in the plan the arrangements for utilizing evaluation results for programme improvements. If there are no such arrangements, the team should work out practical ones and put them into the plan.

This step is very important, since the reason for evaluation is to improve the programme so that the health education objective will be met and the programme goals achieved.

3. GLOSSARY OF HEALTH EDUCATION TERMINOLOGY

1.	**Acceptance**	Adoption of a new idea or a measure, e.g., a health practice or health measure.
2.	**Action research**	Research carried out in connection with ongoing or action programmes, or carried out in field projects to test the extent to which the programmes are reproducible.
3.	**Activity**	Performance of any work. Synonymous with work, effort, input, etc.
4.	**Adapt**	Apply, with modifications suitable to the conditions (in contrast to "adopt" which means to accept or apply something exactly as it is).
5.	**Attitude**	Tendency to act. The distinguishing evidence of attitude is behaviour.
6.	**Baseline data**	Information on facts which indicate the starting point in an activity or group of activities and which are essential for evaluation.
7.	**Behaviour**	Manner of acting or of conducting oneself. May be health habits, health practices, etc.
8.	**Category of workers**	A group of workers who have similar duties, for example, categories of nurses, sanitary inspectors, etc.
9.	**Channels of communication**	Means of or media for transmitting information or ideas among individuals or groups.
10.	**Community**	A group of people living in the same area that may or may not coincide with administrative or political boundaries.
11.	**Criteria**	Established standards by which a thing is measured.
12.	**Culture**	Inherited artefacts, goods, technical processes, ideas, habits and values; the distinctive way of life of a group of people.

13.	**Cultural characteristics**	Distinguishing qualities or traits in ways of feeling, thinking, believing and acting which are followed or practised by a group of people.
14.	**Demography**	Study of the major attributes of a population.
15.	**Demographic characteristics**	Distinguishing features of a population such as size, distribution, fertility density, mobility, immigration and emigration as well as birth and death rates.
16.	**Economic characteristics**	Distinguishing qualities of the sources of production, distribution and consumption of goods, including manpower, wages, agricultural products and natural resources.
17.	**Ecological characteristics**	Circumstances influencing or resulting from the interaction of man with his environment. *Examples*: limited food because of limited water, or danger of rabies in man from wild foxes living near people's houses.
18.	**Evaluation**	Process of determining the value or amount of success in achieving a predetermined objective.
19.	**Goals**	Those ends toward which an individual's or an agency's motives are directed; the desired or expected outcomes.
20.	**Habit**	A usual way of action or an act performed without thinking. Example in the field of health: washing one's hands before handling food.
21.	**Health education component**	That part of a health programme which is concerned with bringing about, through educational methods and means, the health behaviour which is required on the part of the people in order to achieve the programme goals.
22.	**Health practice**	In general use, synonymous with health habits.
23.	**Health problem**	A statement of a situation or condition of people or their environment which has or has potentially an adverse effect on people's health or well-being.
24.	**Health programme**	A plan of interrelated activities (or tasks or efforts) designed to achieve set health objectives.
25.	**Implementation**	The carrying out of a plan.
26.	**Instrument**	A device to facilitate measurement, such as a thermometer; a tool or means by which something is done. *Example*: a questionnaire may be an instrument to collect baseline data or an instrument to collect data on health services.
27.	**Leaders**	Those members of a group who influence the voluntary behaviour of their fellows in a stated direction.
28.	**Leadership pattern**	The way in which leadership is distributed in a community, and the interrelationship of the leaders.
29.	**Media**	The means used in communicating information from one person to another, that is, the intervening substance through which impressions are conveyed. The materials used in an educational transaction are referred to as media.

30.	**Method**	The *how* of an activity. In health education, methods are the techniques of communicating information from one person to another or the way in which an activity or series of activities is carried out.
31.	**Paramedical personnel**	All the professions allied to medicine which together make up the team of health personnel, i.e., nursing and midwifery, sanitation, dentistry, veterinary health, pharmacy, physiotherapy, statistics, microbiology, etc. (Organizational study by the WHO Executive Board, *Off. Rec. WHO*, 1963, 127: 184).
32.	**Participation**	The act of taking part in something.
33.	**Plan**	A detailed and systematic programme for action.
34.	**Planning**	Process through which a decision is transformed into action.
35.	**Social psychological factors**	Influences arising from the relationships among individuals and groups in a society or community and the ways of thinking and behaving which develop from these relationships.
36.	**Supervision**	The act of directing work or activities with a view to educating and helping as against inspection, which implies close examination to judge quality or detect failures.
37.	**Target group**	A group or section of the population selected for special attention on the basis of having special characteristics, e.g., susceptible groups, those suspected of having a disease, leaders with an ability to influence other people, etc.
38.	**Values**	The outcome of human choices among competing human interests.[1]
39.	**Voluntary organizations**	Those organizations supported by voluntary (rather than State) funds.

[1] Bennis *et al.* *The Planning of Change*, New York, Holt, Rinehart and Newton, 1961, 110 p.